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MMIA Employee Benefits Administrator's Handbook

General Information

Welcome to the Montana Municipal Interlocal Authority (MMIA) Employee Benefits (EB) program! MMIA is a member-owned risk retention pool where cities and towns join to cover each other's expenses and benefit from the stability of being a pool member. The EB program provides self-funded medical, dental, and vision coverage to employees via their employer city or town. We also make available access to affordable life insurance coverage. The EB program is the newest program to MMIA, added in 2004. It has grown rapidly from the 43 member cities and town in the original purchasing pool to 90 members today. The program provides benefits to over 2,700 employees and their dependents.

MMIA uses the services of Third-Party Administrators (TPAs), such as Allegiance, to process claims; however, the ultimate plan design and implementation comes from MMIA. We comply with state and federal requirements and use the advisement of our EB committee, made up of members, to stay responsible and innovative. The majority of MMIA EB plan costs are actual claim dollars. To manage the rising costs of claims, MMIA promotes an annual wellness program that includes a health screening, encouraging utilization of cost-containment initiatives through case/disease management, offering resources such as the Employee Assistance Program (EAP), CRx International Mail Order, Teladoc, Healthcare Bluebook, and providing education to our members and participants.

This guide is designed to give our benefit administrators a quick reference for common questions and issues that occur while managing employee benefits. It does not replace, nor supersede, the program agreement or other plan documents provided to your member city or town.

Important Health Privacy Information:
Plan administrators, such as city clerks or managers, may find themselves in a position of assisting employees with health questions. Privacy laws under the Health Insurance Portability and Accountability Act (HIPAA) are clear in their interpretation. Employers should not be handling private health information for their employees. This means that if an employee comes in with questions about claims, they should be directed to the customer service of our vendors. Although it may seem like a good service to do the footwork or even listen to the details that an employee freely provides, it is actually placing both you and your city/town in a dangerous position. HIPAA enforces violations of private health information breeches and will fully investigate complaints.

FAQs at a Glance

When do new employees have to enroll in benefits?

A new employee or an employee that is newly eligible for benefits (begins working the minimum number of hours) has 31 days from the date of hire (or date they start working the minimum hours) to complete their enrollment request and have it approved by the benefits administrator. Even if your city or town may have a waiting period that is greater than 31 days, the request needs to be completed within the 31-day period.

What is the difference between the initial enrollment period and the waiting period?

The initial enrollment period is 31days from the date of hire when an employee can enroll in benefits. The waiting period, on the other hand, is the time an employee must be actively employed and eligible for benefits before their benefits begin. The length of the waiting period varies depending on the city/town's personnel policy.

I don't know which online form to use or how to fill it out.

Each of the enrollment forms can be found on www.mmiaeb.net/forms. If you click on one of the forms, a description for the use of that form appears. If you are still unclear, contact the Employee Benefits (EB) team for assistance in determining which form to use and for step-by-step guidance on completing the form.

Do I have to do anything when an employee retires and keeps benefits?

Yes, you or the employee will need to complete the Change Form to indicate that the employee is retiring. This ensures that the retiree and, if applicable, their covered dependents' eligibility is accurately reflected. The change form must be submitted no later than 31 days after the employee's last day of work.

Are newborns automatically covered?

No, but a newborn can be added to the coverage if the request is made and approved by the benefits administrator within 31 days of birth. A social security number is not required to add a newborn. Once the social security number is issued, please send the information via a secure email or document upload to the EB team.

What is the plan year for benefits through MMIA?

The plan year for benefits through MMIA begins on July 1 of each year. However, the deductible period is typically based on a calendar year. *

*City of Helena employees deductible runs concurrent with the plan year.

How do we change the benefits my city/town offers?

Each spring, MMIA provides members with the opportunity to change the benefits offered through MMIA. Once the Board of Directors sets the final rates, a full list of benefits and their costs is provided to each member. After selecting the desired benefits, complete the Annual Group Election Form, and the new benefits will be available to employees on July 1. Employees may need to complete an Open Enrollment (May 15 to June 15) request to participate or change their benefits for the next plan year.

Benefits Administrator

The benefits administrator is the person or team from your city/town that works with your employees to ensure they are properly enrolled in the benefits available to them. The MMIA EB team is available to assist you with this very important responsibility. We can provide education to you and your employees on the benefits offered through MMIA and assist in answering employee questions or with issues that arise.

To enroll or make changes, employees must complete the appropriate form, which is available on the EB website. The benefits administrator will receive an email notification and may need to approve or decline the request before MMIA can complete the process. Online forms are required for events such as new hires, qualifying events, retirement, and termination of coverage. Employees have 31 days from the event date (date of hire, marriage, birth, etc.) to complete the form and have it reviewed and approved by the benefits administrator. Detailed instructions and the password to access secured pdf attachments are sent directly to the benefits administrator and are available upon request, as well.

A more in-depth explanation of benefits eligibility can be found in the "Eligibility Guidelines" section.

Monthly EB Invoices

The Employee Benefits Program operates differently from other MMIA programs, as members receive monthly invoices for their benefits. The billing process takes place on the 15th of each month (or the first business day after the 15th if it falls on a weekend or holiday), with invoices for the following month sent in a secure email to the benefits administrator or a designated representative. To ensure accurate invoicing, any changes to the members' benefits plan must be approved by noon on the business day before billing. Payments for the monthly invoice are due on the 1st of each month (for example the March invoice is processed on February 15 with payment due on March 1).

MMIA does not prorate monthly premiums. If an employee terminates coverage during the month, their coverage extends until the end of the month. If coverage begins on or before the 15th, the entire month is billed. If coverage begins after the 15th, the first bill is for the following month. Newborns are not automatically enrolled.

The invoice has two parts: an overview of the bill's content on the first page, and the details that make up the totals on subsequent pages. The detail section(s) lists individual participant IDs with coverage and premium amounts. Any credits or charges affecting prior billing periods will also be reflected in the detailed section of the bill.

Timely review of your bills is crucial to ensure their accuracy and to report any errors before the next billing cycle. Please verify the following items when reviewing your bills:

- For individuals listed in the "Active" section, ensure that they are currently employed.
- For individuals listed in the "Retired" section, make sure they are either a retiree or the spouse of a retiree who has paid the monthly premium for coverage.
- Check that the billed amount for everyone is correct:
    - Confirm that the amount matches your payroll records or deductions.
    - Verify that the amount collected from retirees matches the billed amount.

MMIA must be paid as billed, and any differences should be noted on a discrepancy report if there is a difference of more than $5. This form helps maintain an audit trail for both parties in case of questions in the future. The email with the monthly invoice contains an attachment with a link to the discrepancy form. For instructions on accessing the secured email with the EB invoice, please request them from the EB team.

Eligibility Guidelines

To be eligible for employee benefits, each city or town has specific criteria that must be met, such as the classification of eligible employees and the required number of work hours. It's crucial to regularly review the eligibility status of listed employees to ensure they meet the requirements for coverage under the health benefits plan.

- Dependent children can receive medical, dental, and vision coverage until they turn 26 years old, regardless of their student or marital status. Domestic partnerships are covered based on the city or town's policies and must be included in the personnel policy.

- Changing coverage mid-year is only possible within 31 days of a qualifying event, such as change in marital status, birth, or loss of other coverage. Employees can add someone to their plan or change their chosen plan, but they must submit required documentation, such as a certificate of coverage, to prove eligibility.

- Having a baby is a qualifying event, but newborns are not automatically enrolled in the plan. Employees must complete the request to enroll the newborn within 31 days of birth. Failing to enroll a newborn within the time frame means there will be no coverage until the next Open Enrollment period or another qualifying event.

- A retired employee (or the benefits administrator) must complete the appropriate change notice if they are keeping benefits as a retiree.
    - If they are under 65, they can remain on the medical plan, premium payments are made to the city/town.
    - Retirees or their covered spouses are not eligible for the MMIA medical coverage once they are eligible for Medicare. See the "Retirees" section for more information.

Each year, both individual participants and member groups get the opportunity to make changes to their coverage during the annual Open Enrollment period. It begins with the group (city or town) completing the Group Election Form, indicating the chosen medical, dental, vision, and life options, and reviewing the required eligibility hours and probationary periods.

- Employees can waive medical coverage if they have other eligible group coverage, and it's recommended that they complete the open enrollment form each year to indicate their choice to waive coverage.
- During the participant's Open Enrollment period from May 15 to June 15, eligible employees can make changes to their coverage, such as adding an eligible spouse or dependent or switching plan options, before it takes effect on July 1st.

Please notify MMIA as soon as possible if there are changes to an employee's name, address, or marital status.

New employees are eligible for benefits according to their city's probationary policy (also called a waiting period) and have 31 days from their date of hire to enroll. They may also become eligible for benefits outside of the annual open enrollment period if they experience a qualifying life event (QLE).

If your city or town policy allows, ***elected officials*** can enroll and become eligible for benefits. You must provide MMIA Employee Benefits Program with a copy of the resolution or policy. Newly elected officials can enroll on the first day of their term and have up to 31 days to do so.

Identification cards are sent to the employee's address of record and display the Group Name, Group ID number, name of the covered person and their dependents, and types of coverage. Social Security numbers are not displayed to protect privacy.

Terminations and Leaves of Absence

- An employee's signature is not required for termination. Simply complete and submit the online Termination form within 31 days of the employee's termination, and MMIA will handle the rest.

- Timeline - Terminating benefits must be done in a timely manner to comply with federal COBRA requirements. Employers must notify terminating employees of their COBRA rights within 30 days and dependents within 60 days. Failure to comply with these timeframes may result in the employer being responsible for any medical costs during that time.

- Reduced Hours - If an employee's hours are reduced below the eligibility requirement, it is considered a COBRA event. Employers must notify MMIA of this event within 30 days by completing a termination form for the employee. Changes in coverage for dependents must be submitted within 60 days.

- Retro-Termination - MMIA cannot retroactively terminate coverage, except in cases of non-payment of premiums or misrepresentation by the participant. If termination is not submitted within 30 days, the city must still pay through the end of the month in which notification was given.

- Leave of Absence - Employees and their families can remain covered under the policy without electing COBRA during certain approved leaves of absence, such as family medical leave. Written policies must be in place and provided to MMIA if requested, and employers are encouraged to reach out to us immediately if this situation arises. Premiums must continue to be paid during these leaves.

- Workers Compensation Leave - A written policy must be in place and consistently followed if an employee is out on Workers' Compensation disability.

- Seasonal and Temporary Layoff Workers - Seasonal or temporary workers must be terminated from benefits when they are laid off, and coverage will continue through the end of the month. If they are rehired within 63 days, their coverage remains intact. After 63 days, they are treated as new employees and probationary periods apply.

Retirees

Retirees and their spouses who are covered by MMIA medical plans can remain enrolled in medical coverage until they reach the age of 65, while dental and vision coverage can be maintained indefinitely as long as the monthly premiums are paid. It's important to note that if retirees or their spouses choose to terminate their coverage, they will not be able to re-enroll in the plan. In cases where the retiree's spouse is not yet 65 and the retiree becomes ineligible for medical coverage, the spouse can continue coverage independently. If a retiree passes away while covering a dependent, the dependent can continue to receive coverage by paying premiums to the city. Dependent children can be covered until the age of 26 in this scenario.

For retirees and their covered spouses turning 65, the medical coverage will end on the last day of the month in which you turn 65. MMIA sponsors a group Medicare Advantage Plan for those over 65. Visit https://mmiaeb.net/retirees/ or contact the EB Department for more information.

MMIA is required to send COBRA notices to retirees. If the retiree is under the age of 65, staying on the medical plan is generally more financially beneficial than electing COBRA. COBRA administers the current plan with an additional 2% administration fee. If an employee retires, is less than 65, and wishes to continue benefits, complete the change from Active to Retiree status using the online Change Form.

Life Products

The Basic Life program is a fully insured employer-paid product offered by some cities and towns to their employees. The city or town decides the coverage amount and whether to offer dependent coverage. Eligible employees are required to participate, and the benefit level must be the same for all employees in the group. Coverage is reduced by 50% at age 70. The rates are competitive and evaluated annually. Children must be under 26 years of age to be eligible. Retirees cannot remain on the Basic Life coverage, but they can convert their policy within 30 days of retirement.

MMIA also offers competitively priced Voluntary Group Life and Accidental Death & Dismemberment (AD&D) programs. The city or town decides whether to offer this benefit to employees, and the premiums are paid 100% by the employee. Each employee can choose the amount of life benefit they need, and the rates are based on the age of the covered person. The guaranteed issue amount for this product is $350,000 for the employee, $50,000 for the spouse, and up to $10,000 for dependent children in $1,000 increments (minimum of $2,000). Employees can apply for up to five times their salary, in increments of $5,000, up to $500,000. Spouses are eligible for 100% of the employee's amount, up to $500,000. Any amount more than the guaranteed issue requires a health statement. If an employee does not enroll during their hiring process, they will need to complete a health statement during the next Open Enrollment.

To file a life claim, please contact MMIA Employee Benefits at 1-800-635-3089, option 4.

Coordination of Benefits

Your plan includes guidelines on how it interacts with other insurance coverage that your employees or their dependents may have, as well as how it interacts with Medicare for eligible employees.

For active employees enrolled in the plan, MMIA is considered the primary insurance for both the employee and their dependents. If the dependents have other coverage, MMIA may be secondary.

MMIA follows federal regulations on coordinating benefits with Medicare and cannot deviate from these rules. Additionally, the plan will coordinate with Medicare even if the employee has not enrolled in or purchased Medicare and will only pay for expenses not covered by Medicare.

Wellness Program

As a member of the MMIA EB Program, your city or town has access to a comprehensive Wellness Program that promotes wellness among employees, spouses, and retirees that are enrolled in a medical plan. The program is designed to provide tools to manage your well-being and healthcare costs. Dependent children are not eligible to participate. You can find Wellness Program activities at https://mmiaeb.net/wellness/.

The Wellness Program offers four incentive activities worth $50 each, providing a total possible incentive of $200. These activities include Health Screenings, 80% Employee Participation, Health Screening Review call with a Take Control health coach, and Education incentives. Health screenings will be provided on-site by It Starts With Me (ISWM) or at a Montana Health Center (MHC).

To receive incentives, eligible employees must complete Health Screenings, 80% Employee Participation, and Education activities between July 1 and September 30. Health Screening Review with a Take Control health coach must be completed by the first Friday of November. New employees enrolled on a medical plan will be informed of the Wellness Program upon enrollment and will be allowed to participate in the program if they are active between July 1 and September 30.

MMIA will distribute incentives upon completion of the Wellness Program cycle, and only eligible participants on the medical plan at the time of distribution will receive them. For more information, https://mmiaeb.net/wellness/ or contact MMIA Employee Benefits at 1-800-635-3089 option 4.

Participation in this program is voluntary, and the MMIA Wellness Program was developed in compliance with the EEOC wellness rules and does not violate anti-discrimination laws as determined by the Americans with Disabilities Act and Genetic Information Nondiscrimination Act. MMIA maintains the privacy and security of personally identifiable health information.

The MMIA Wellness Program will be evaluated and updated annually, and MMIA reserves the right to alter the Wellness Program at any time.

Appeals

While employers must not be involved with individual claims issues to comply with HIPAA regulations, employees may ask for guidance on how to dispute claim results. To initiate an appeal, the Explanation of Benefits (EOB) has appeal information on the backside, and the Summary Plan Document (SPD) provides further details on the appeals process. Typically, there are two types of appeals: pre-service and post-service.

Pre-service appeals apply when an individual is attempting to pre-authorize a service, such as surgery, and it has been denied. Post-service appeals are for situations where someone is appealing an already processed claim and its outcome. For example, if someone disagrees with a service being denied as non-emergency when it was an emergency, they may file a post-service appeal. In either case, the covered person must submit an appeal in writing within 180 days of the denial. If they fail to submit it within 180 days, they have no further recourse. Different levels of reviews are available to allow for multiple opportunities to reconsider the denial.

As the employer, the city or town should avoid becoming involved with individual claims issues. If a participant is having difficulty obtaining the desired results or information, direct them to the appropriate vendor or MMIA. HIPAA regulations do not allow for any deviation from this rule, even if the affected individual is a neighbor or co-worker.

Health Care Reform

The enactment of the Patient Protection and Affordable Care Act (PPACA), also known as the health care reform law, brought about several changes in the requirements for plans, individuals, and employers. MMIA Employee Benefits is committed to keeping up to date with all the PPACA requirements and serving as a resource to assist you.

Required Changes under PPACA:

- Plans cannot have a lifetime maximum.
- Dependents can stay on the plan until age 26.
- Preventive services, including cancer screenings, must be paid at 100%.
- No pre-existing condition exclusion.
- The eligibility waiting period cannot exceed 90 days.
- Re-insurance and research fees.
- Employers must report premium amounts.
- "Pay or Play" penalty.

MMIA's Response:

- All MMIA plans comply with the required actuarial value.
- Changes to the benefit structure were immediately implemented upon the passage of the bill.
- Two years of data show no impact on rates resulting from immediate structure changes.
- MMIA will continue to pay the re-insurance and research fees.
    - These additional costs will not be the responsibility of employees or employers to collect, report, or pay. Both fees will continue to be taken from a reserve fund to avoid impacting rates.
- PPACA does not affect MMIA plans to the extent that we cannot offer the same coverage or better.

Notices

MMIA is required to distribute various notices to individuals, which can be found on the company's website at https://mmiaeb.net/forms/notices/. These notices include the following:

- Medicare Part D Credible Coverage Notice: This notice informs Medicare-eligible policyholders if their drug coverage is creditable, meaning it is expected to pay on average as much as the standard Medicare drug coverage.
- Notice of Privacy Practices (NPP): This notice explains how an individual's medical information may be used and disclosed, as well as how they can access this information.
- Children's Health Insurance Program Re-Authorization Act of 2009 (CHIPRA) Notice: Employers must distribute this notice to inform employees of their rights to enroll their children under their health plan if they lose coverage under Medicaid or a state-sponsored child health insurance program.
- Women's Health and Cancer Rights Act Notice: This notice informs individuals of their rights to receive coverage for breast reconstruction after a mastectomy.

Resources and Forms

This Benefit Administration Handbook provides information about the forms, documents, and internet resources that are available to employees. The following forms are available on the Claims Reimbursement and Mail Order Forms section of the website at https://mmiaeb.net/forms/ or can be requested by calling the EB department:

- Authorization for Release of Information
- Prescription Drug Claim
- Vision Out-of-Network Claim Reimbursement
- Basic and Voluntary Life and AD&D
- Medical claim forms (if needed)

The Summary Plan Descriptions (SPD) for medical, dental, and vision plans, along with a plan index for easy reference, can also be found on the "Benefits" section of the website.

The following internet resources are available to employees:

- U.S. Treasury Department website for Health Savings Accounts http://www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx
- Medicare Information http://www.medicare.gov/
- Allegiance Benefit Plan Management for medical coverage questions https://www.askallegiance.com/ 1-866-339-4308
- Delta Dental for dental coverage questions https://www1.deltadentalins.com/ 1-800-521-2651
- Vision Service Plan for vision coverage questions https://www.vsp.com/ 1-800-877-7195
- ProAct for pharmacy benefit management https://secure.proactrx.com/ 1-888-869-4600
- Allegiance Care Management for case management https://www.askallegiance.com/Resources/CareManagement 1-800-877-1122
- Take Control for disease management and maternity management https://www.takecontrolmt.com/ 1-800-746-2970
- Sapphire Resource Connection for employee assistance program https://www.sr-connection.com/ 866-767-9511 (24-hour toll-free help line)
- Teladoc for telemedicine https://www.teladoc.com/ 1-800-TELADOC (1-800-835-2362)
- Healthcare Bluebook for finding the best prices for healthcare services, click on "Cost Transparency" on the main page of the Allegiance website https://www.askallegiance.com/
- CRx International Mail Order presctiptions for obtaining brand name medications at no cost https://www.crxintl.com/plan/?planid=MMIA 1-866-488-7874

Employees are reminded that any interaction with each vendor is confidential.

FAQs & Definitions

Deductible: A deductible is a predetermined amount that an individual or family must pay within a benefit period before the insurance plan will cover any expenses.

Benefit Percentage: This is the percentage of costs that the plan and the patient will share after the deductible has been met. For example, the plan may cover 80% of allowable expenses, while the participant pays the remaining 20%.

Annual Out-of-Pocket Maximum: This is the maximum amount that the patient will be responsible for paying before the plan covers 100% of the Maximum Eligible Expense (MEE).

Formulary Listing: This is a list of medications covered by the insurance plan, and using the formulary can save money through discounts. It's important to use the formulary drug listing, particularly for those in cities and towns covered by the drug card plan.

What's the difference between Professional and Facility services?
Professional services refer to those provided by individual doctors, while facility services are those linked to clinics or hospitals. It's important to distinguish between these two types of services, as it can be confusing when multiple bills are received for the same procedure. For example, a surgery performed at a hospital may result in separate bills for the surgeon and anesthesiologist (professional services) and the hospital and lab work (facility services).

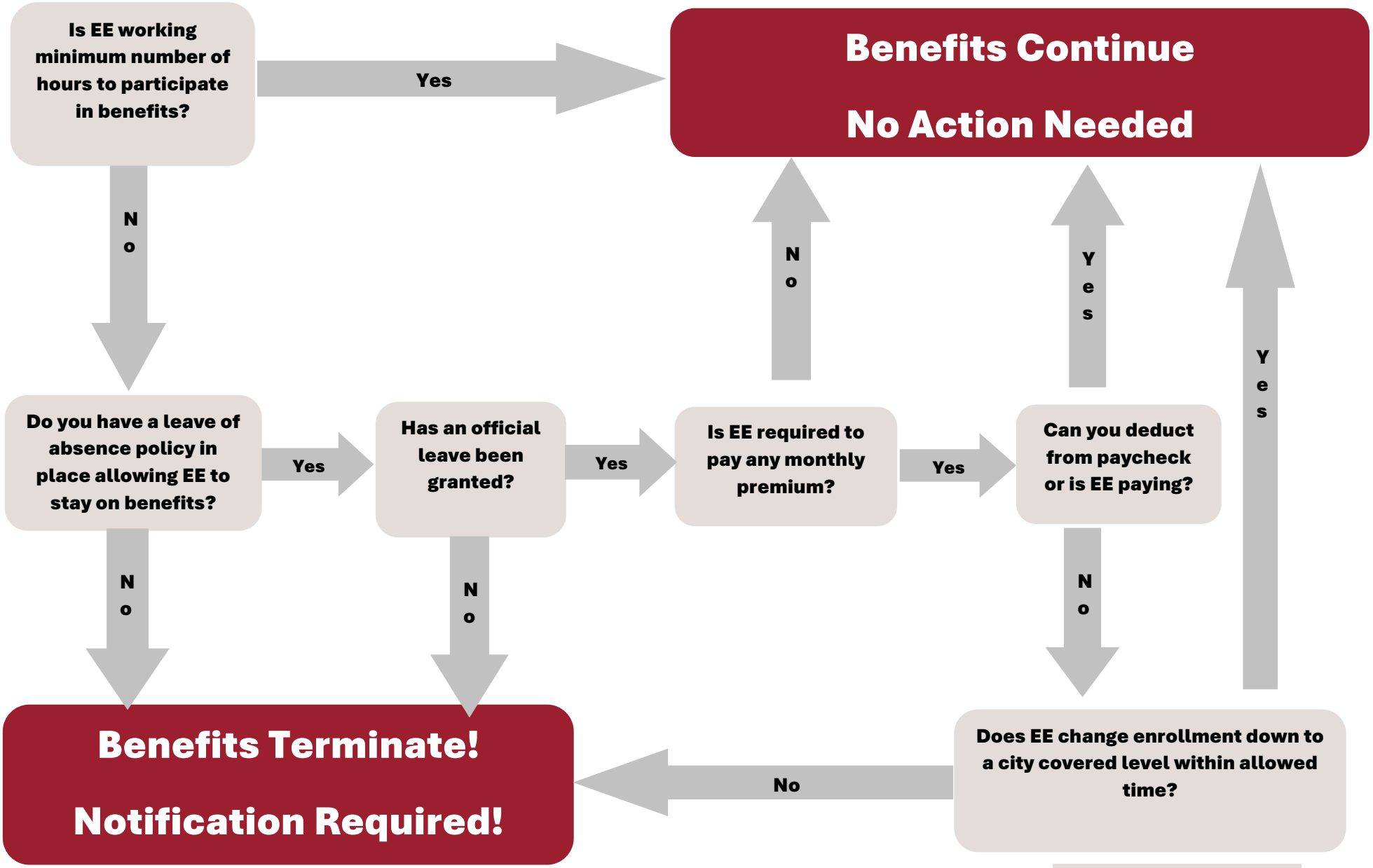
What's the difference between Participating Provider and Non-Participating Provider for my medical coverage?
Providers who are contracted with Allegiance and Cigna agree upon pricing for services. If services are rendered by a participating provider, the insurance plan covers the agreed-upon amount, and the provider cannot bill the patient for any additional costs beyond the Procedure-Based Maximum Expense (PBME). If services are rendered by a non-participating provider, the plan will only cover up to the PBME, and the patient may be responsible for paying any additional charges.

What's the difference between Flex and Health Savings Accounts?

- A flexible spending account (FSA) is when an employer deducts a tax-free portion of an employee's pay each year to fund an account that can be used for qualified medical expenses. FSA funds must be used within the tax year and cannot be changed until the next annual Open Enrollment period.
- A health savings account (HSA) is only available with a high deductible health insurance policy (HDHP). A tax-free contribution is made to the account, and the funds can be used to cover medical expenses, including the deductible. HSA funds are portable, meaning they can be kept even if the policy is terminated.

It's important to note that neither FSA nor HSA products are offered through MMIA, so employees should contact their HR department for information on whether these products are offered through their city or town.

Leaves of Absence and Employee Benefits Appendix



EE = Eligible Employee